CITY OF RIVERSIDE HEALTH BENEFITS ENROLLMENT/CHANGE FORM

Name of Subscriber: Last **First** **M.I.** **Social Security No.**

Address **City** **State** **Zip**

Department/Division **Hire Date** **Work Phone** **Home Phone**

Bargaining Unit Name **City Employee ID Number**

Birth Date:_____

Sex: Male Female

Marital Status (Circle One)

Single Married Divorce

Marriage/Divorce Date:

_____

Indicate actions that apply:

- ☐ New Enrollment
- ☐ Active Employee
- ☐ Retiree
- ☐ Medicare Plan
- ☐ Cobra
- ☐ Edit Name/Address
- ☐ Student Status
- ☐ Delete Dependent
- ☐ Add Dependent
- ☐ Open Enrollment
- ☐ Change Medical Group
- ☐ Change Primary Care Physician
- ☐ Cancel Coverage Eff._____
- ☐ Other_____

Choose Your Health Plan/Type (Select One)

☐ Kaiser Permanente/VSP #_____

☐ Blue Cross (CaliforniaCare)/VSP #_____

Choose Your Coverage Type (MUST SELECT AN OPTION)

_____HMO High _____HMO Midway _____HMO Low

_____BC PPO _____BC Out-of-State _____Medicare

If dependent(s) have a different address, please indicate. <u>If you have a college age dependent this entire section must be completed.</u>

Student/Dependent Name **Address** **City** **State** **Zip**

Name of Institution **Address** **City** **State** **Zip** **<u># of Units</u>**

Do any dependents have other health insurance? If yes, please complete:

Dependent's Name Insurance Company Name Policy No.

If you are a Retiree and are over the age of 65, do you qualify for Medicare? (Please circle one) **YES** **NO**

List Eligible Person(s) to be Covered OR Person(s) to be Deleted

Relationship	Last Name First M.I.	Social Security No.	Birth Date	Age	*Medical Group/IPA #	Blue Cross HMO IPA Primary Care Physician Code	Existing Patient
☐ **Self**							☐ Yes ☐ No
☐ **Spouse** ☐ **Domestic Partner**							☐ Yes ☐ No
☐ **Son** ☐ **Daughter**							☐ Yes ☐ No
☐ **Son** ☐ **Daughter**							☐ Yes ☐ No
☐ **Son** ☐ **Daughter**							☐ Yes ☐ No
☐ **Son** ☐ **Daughter**							☐ Yes ☐ No

*Blue Cross HMO (CaliforniaCare) participants must select a Medical Group and Primary Care Physician and list name(s) and address exactly as it appears in the directory.

Enrollment Agreement and Payroll Deduction Authorization

I acknowledge that the above information represents my enrollment choice(s). I understand my coverage elections cannot be changed until a future benefits enrollment period. I represent that to the best of my knowledge and belief, all statements and answers made on this form are true and complete. If applicable, I authorize any insurance company, hospital, physician, or any other health care provider to release all information to all those who may have a bearing on benefits available under this plan. Adjustments may be made to increase or decrease the amounts specified for deductions by the City, provided that the method, manner and amount of such deductions are in full compliance with applicable laws and administrative rules and regulations of the City. The employee portion of the deduction will be automatically deducted pre-taxed on a biweekly basis (This excludes Domestic Partner participants). If I am adding a domestic partner, I will provide a copy of the "Declaration of Domestic Partnership" which can be provided by the Secretary of State, in order for my domestic partner to be eligible for benefits. I understand if I am hired on the 1st, 2nd or 3rd of a month, my benefits become effective the 1st of the following month; if I am hired on the 4th through the end of the month, then my benefits are effective the first of the month following 30 days of employment.

I have read and accept the arbitration and privacy information on the reverse side of this form._____
I understand and agree to the terms and conditions described on both sides of this form. **Initials**

Employee Signature Date

Original/Insurance Co. Yellow/Employer Pink/Employee

Important Information for Kaiser HMO Participants:
Some of the health plans offered by the City of Riverside, including Kaiser Foundation Health Plan, require resolution of medical malpractice and other disputes through binding arbitration. If you select one of these plans, you agree to give up your right to a jury or court trial for resolution of these disputes.

For additional information about each plan's arbitration provision, please refer to the Disclosure Form and Evidence of Coverage, copies of which are available from Human Resources.

Blue Cross of California:
ARBITRATION AGREEMENT: If your coverage is provided under an employer-sponsored plan subject to ERISA, certain disputes may not be subject to the Binding Arbitration provision.
Any dispute connected with a Blue Cross plan or an affiliate ("Blue Cross"), whether related to the agreement of or cancellation of care, or the relation to care or its delivery, must be resolved by arbitration if the amount sought exceeds the jurisdictional limit of the small claims court. By agreeing to arbitration, the member and Blue Cross acknowledge that they surrender their right to a court trial by jury and also agree to relinquish their right for class arbitration against each other. Arbitration findings will be final and binding unless California or Federal Law provides for the judicial review of the arbitration proceedings.